TARZANA TREATMENT CENTERS, INC.
Charity Care Application

Patient Name	**Facility:**	**DOS:**
Patient Number	**Confidential Financial Statement (Application)**	

RESPONSIBLE PARTY

Name	Marital Status	Social Security Number
Street Address, City, State, Zip	How long at this address	Home Phone
Employers Name and Address (If Unemployed –How Long)		Business Phone
Position / Title	Monthly income – Gross / Monthly income - Net	Length of current employment

SPOUSE

Name	Social Security Number
Employer Name and Address	Business Phone
Position / Title — Monthly income – Gross / Monthly income – Net	Length of current employment

DEPENDENTS

Name & Year of Birth of all dependents in household	Total Number of dependents in household	Do Any Other Persons Contribute? If Yes, Amount: Yes/No Amount

INCOME PER MONTH & ASSETS

Dividends, Interest	$	Child Support / Alimony	$
Public Assistance / Food Stamps	$	Rental Income	$
Social Security	$	Grants	$
Unemployment Compensation	$	IRA	$
Workers' Compensation	$	Other	$
Savings	$		

EXPENSES PER MONTH

Mortgage / Rent Payment:	$	Balance: $	Medical / Dental		$
Own Home? (Yes/No)			Doctor – Name		$
Food	$		Doctor – Name		$
Utilities:	$		Doctor – Name		$
Electric	$		Credit Cards:		$
Gas	$		Visa	Limit	$
Water / Sewer	$		Mastercard	Limit	$
Trash	$		Discover	Limit	$
Phone	$		Other	Limit	$
Cable	$		Installment Loans		$
Auto Payments	$		Child Support		$
Auto Expenses	$		Miscellaneous Expenses		$
Insurance:					
Auto Premium	$				
Life Insurance	$				
Health Insurance	$				

OFFICE USE ONLY
Gross income
Net income
Total Expenses
Total Net income(loss)

To my knowledge the information provided above is true.
I authorize a Credit Bureau Report to be secured by the Tarzana or its agent to verify my financial standing.

PATIENT/GUARANTOR SIGNATURE

DATE